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MEDICAL JOURNAL



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Hypnosis for Asthma

SIR,—Your leading article on hypnosis in medicine (12 October, p. 67) expresses the hope that more physicians will explore the possibilities of this method of treatment in asthma.

As one of the physicians participating in the British Tuberculosis Association's trial of hypnosis in asthma reported in the same issue (p. 71), I would like to draw attention to the possible dangers of widespread use of hypnosis, particularly in patients with severe asthma on long-term corticosteroid treatment. Such patients were excluded from this trial and no evidence is presented of their response to hypnosis.

The trial established that it was possible, in some patients, to suggest successfully that there would be freedom from wheezing without any improvement occurring in their respiratory function. If this should happen to the severe asthmatic under long-term steroid treatment, he may reduce his steroid dosage, increase his bronchodilator consumption

and slip into status asthmaticus without being fully aware of what is happening. Sticky mucous plugs throughout the lungs cannot be removed by suggestion. The patient could develop severe hypoxia and sudden death might ensue. I feel very strongly that hypnosis in severe asthma should only be undertaken by those who have considerable experience in the management of such cases.

We have not yet solved the problem of the rising death rate in asthma, but it is thought by many who are interested in this subject that the main reasons are: failure to recognize status asthmaticus; under-prescription of steroids; and abuse of bronchodilator aerosols. I submit that indiscriminate use of hypnosis in severe asthma could add to these risks.—I am, etc.,

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House Dust Allergy

SIR,—The British Tuberculosis Association report (28 September, p. 774) fortifies an impression which many practitioners must have formed in their own work. But it would be a great pity if the association's findings were taken as totally discrediting the use of house-dust extracts. In ordinary practice they can be used more flexibly than is feasible for a blind trial.

In pre-seasonal desensitization we have no choice but to work by programme, because during the period of the treatment we are working blindly; apart from the occasional reaction we get no feed-back of information as to what the injections are doing. In treating a patient with a current baseline of symptomatic activity, as is usually the case with house-dust or bacterial vaccine treatments, the position is different. If the injections

are working, we ought to see this reflected in the symptoms and thereby have repeated opportunities to adjust dosage and timing towards what seems best for the individual.

It has sometimes been claimed that prompt symptomatic effects are mostly encountered with doses much smaller than those generally used in standard programmes. Test-dosing for symptomatic reaction was, and indeed remains, the only way of selecting patients for treatment; this clinical sensitivity to small doses is quite unrelated to the local skin-test reactivity, is usually to be elicited in those who have experienced direct nasal or bronchial irritation from commonplace house-dust inhalation, and may also be elicited in a few of those who have not noticed such effect. It may manifest as aggravation or remission

according to the dose, and successive remissions may become longer, leading to an effective treatment. In developing treatments on these lines I found I had been rediscovering possibilities related to those described by Hansel¹ and by others who have reported favourably on small-dose treatments in various connexions. I can well understand why such treatments have never come into wide use: there are certainly difficulties in objective control and the procedure is exacting. Each dose must be decided at the time according to progress. Hence one cannot give a programme but must continue seeing the patient oneself. The next dose is due only when remission from the preceding one is beginning to fade. This means that the patient must have opportunity to attend when he finds it appropriate, which complicates clinic arrangements.

The B.T.A. report does not refer to nasal symptoms, which are often associated with asthma. My own work has been mainly on patients with nasal symptoms, though associated asthma has been the main problem in some of these. Some asthmatics with an entirely normal nose may respond, but as a class they seem less likely to do well. They may include more cases of "personal problem" asthma. Asthmatics with onset of the disease in later life, as also patients awaiting necessary nasal surgery, may suffer aggravation from effective doses but cannot often be usefully treated. The condition to which house-dust injections are applicable appears to be a disorder in the vascular and secretory behaviour of mucous membranes, which may or may not be associated with asthma. I believe house-dust extracts deserve much more diversified clinical and experimental physiological study than they have yet received.—I am, etc.,

R. M. MORRIS-OWEN.

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REFERENCE

¹ Hansel, F. K., *Clinical Allergy*, 1953. London